

## Maternity Care Program Intake Form



Recipient Name\_\_\_\_\_

Date of Birth\_\_\_\_\_

Address\_\_\_\_\_

County of Residence\_\_\_\_\_

Social Security Number\_\_\_\_\_

Medicaid Number\_\_\_\_\_

If no assistance is required with Medicaid application, provide to eligibility \_\_\_\_\_

DHCP selected\_\_\_\_\_

Notified DHCP & 1<sup>st</sup> appointment obtained\_\_\_\_\_

Risk Status assigned\_\_\_\_\_